



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SURGERY CENTER OF COLUMBIA
725 SOUTH JAMES CAMPBELL BLVD
COLUMBIA TN 38401

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-1725-01

MFDR Date Received

JANUARY 23, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary in the dispute packet.

Amount in Dispute: \$2692.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 16, 2011	ASC Services for CPT Code 21320	\$2692.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective May 25, 2008, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.20, effective January 29, 2009, requires healthcare providers to use correct billing codes.
3. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of benefits dated August 25, 2011 do not list the CPT code 21320, instead it lists code 0490.

Issues

1. Under what authority is a request for medical fee dispute resolution considered?
2. Was the dispute filed in the form and manner required by 28 Texas Administrative Code §133.307 and § 133.20(c)?

Findings

1. The requestor provided services in the state of Tennessee on May 16, 2011 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was not satisfied with the respondent's final action. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.
2. 28 Texas Administrative Code § 133.20(c) states "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills." 28 Texas Administrative Code §133.307(c)(2)(A), requires that the request shall include "a copy of all medical bill(s)"... "as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration"... The requestor submitted a medical bill that appears to be altered because in box # 24 D there is whiteout and the code listed is 21320. Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of the original medical bill(s) nor the bill submitted for reconsideration. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(A).

28 Texas Administrative Code §133.307(c)(2)(B), requires that the request shall include "a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB." The requestor submitted an EOB that lists the code 0490, not 21320. Review of the submitted documentation finds that the requestor has not provided a copy of the original EOB nor the EOB detailing the insurance carrier's response to the request for reconsideration for CPT code 21320. Nor has the requestor provided evidence of carrier receipt of the request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(B).

The Division finds that the dispute was not filed in the form and manner required by 28 Texas Administrative Code §133.307.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____ Signature	Elizabeth Pickle, RHIA Medical Fee Dispute Resolution Officer	6/18/2012 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.